

SENT VIA EMAIL OR FAX ON
Aug/04/2009

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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jul/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy for the Cervical Spine and the Shoulder 3 times a week for 4 weeks

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Chiropractor
AADEP Certified
Whole Person Certified
TWCC ADL Doctor
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Clinical practice 10+ years in Chiropractic WC WH Therapy

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 5/26/09 and 6/17/09
Spine & Sports Medicine 5/18/09 thru 6/8/09
Case Notes 10/20/08 thru 6/9/09
Dr. 4/23/09

PATIENT CLINICAL HISTORY SUMMARY

The injured worker was injured on xx/xx/xx. The injured employee was a passenger of a

vehicle that was involved in a MVA. The injured employee was seen in the emergency department. The injured employee did report loss of consciousness and was referred to a neurosurgeon. She was scheduled for an MRI of the lumbar spine, which revealed disc bulges. She was seen by Dr. who performed an LESI. The injured employee has had pharmaceuticals. The injured employee is now under the care of a chiropractor and undergoing therapy. The injured employee had a DDE on 4-23-2009 and it was determined that the injured employee was not at MMI. The injured employee had 6 sessions of PT as of 5-22-2009 and a second LESI on 5-01-2009 with 4 additional sessions of PT. The injured employee has had a total of 10 sessions of PT. Twelve (12) sessions of therapy are now being requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The injured employee has complete 10 sessions of physical therapy for the xx-xx-xxxx injury. The ODG recommends 10 visits over 8 weeks, which has been completed. Medical records do not support additional treatment beyond the recommended guidelines of 10-sessions.

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#), including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis (ICD9 724.0):

10 visits over 8 weeks

See 722.1 for post-surgical visits

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):

10-12 visits over 8 weeks

See 722.1 for post-surgical visits

Curvature of spine (ICD9 737)

12 visits over 10 weeks

See 722.1 for post-surgical visits

Fracture of vertebral column without spinal cord injury (ICD9 805):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury (ICD9 806):

Medical treatment: 8 visits over 10 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)